NOTICE OF INTENT

Department of Treasury
Board of Trustees of the State Employees Group Benefits Program

Managed Prescription Drug Benefits

In accordance with the applicable provisions of R.S. 49:950, et seq., the Administrative Procedure Act, and R.S. 42:871(C) and 874(A)(2), vesting the Board of Trustees with the sole responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, notice is hereby given that the Board of Trustees intends to adopt the following rule:

Whereas the health and welfare of the employees of the state of Louisiana and of the public school systems within the state is crucial to the delivery of vital services to the citizens of the state; and

Whereas the State Employees Group Benefits Program provides health and accident benefits for approximately 76,300 active and retired employees of the state of Louisiana and many school boards across the state, with over 155,000 total covered individuals; and

Whereas the plan for delivery of and payment for health care services to members of the State Employees Group Benefits Program can impact upon the availability of services necessary to maintain the health and welfare of the covered employees and their dependents; and

Whereas the Board of Trustees of the State Employees Group Benefits Program contracted for a managed prescription drug benefit program implemented on January 1, 1996, in order to improve the plan for delivery of and payment for outpatient prescription drug benefits; and

Whereas it is necessary to amend the Plan Document of Benefits for the State Employees Group Benefits Program in connection with the managed prescription drug benefit program; and

Whereas it is necessary to amend the Plan Document of Benefits for the State Employees Group Benefits Program in order to make changes with regard to lifetime maximum benefits and annual restoration thereof; and

Whereas it is necessary to amend the Plan Document of Benefits for the State Employees Group Benefits Program in order to clarify certain benefit limitations and exclusions in light of recent litigation;

Now therefore, the Board of Trustees of the State Employees Group Benefits Program intends to adopt the following amendments to the Plan Document of Benefits.

Amendment Number 1

Amend the SCHEDULE OF BENEFITS on pages 4 and 5 of the Plan Document in the following particulars:

A. Amend the Lifetime Maximum and Automatic Annual Restoration provisions on page 4 read as follows:

"Lifetime Maximum for all benefits except Outpatient Prescription Drug Benefits on and after January 1, 1996, per Person. . .$750,000*

Automatic Annual Restoration for all benefits except Outpatient Prescription Drug Benefits on and after January 1, 1996. . .$ 4,000*

Lifetime Maximum for all Outpatient Prescription Drug Benefits on and after January 1, 1996, per person (no Automatic Annual Restoration). . ..$250,000"

B. Add a new footnote on page 4, as follows, and redesignate the other footnotes on pages 4 and 5 accordingly:

"*Lifetime Maximum in excess of $750,000 may be accumulated pursuant to the automatic annual restoration."

C. Under "Deductibles" on page 4, amend the prescription drug deductible provision to read as follows:

"Prescription drugs (in addition to and separate from calendar year deductible). . .$150

(Not subject to family unit maximum or annual stoploss)"

D. Under "Percentage Payable after Satisfaction of Applicable Deductibles" on page 5, amend the prescription drug provision to read as follows:

"Prescription Drugs (subject to a minimum copayment of $3 per prescription and not to exceed the brand name and generic maximum allowable charges) . . .90 percent (network), 50 percent non-network, in state, 80 percent non-network, out-of-state***"

E. Amend the redesignated footnote "***" on pages 4 and 5 to read as follows:

"*** A PPO provider or network pharmacy will be paid (after deductibles) at 90 percent of negotiated fee.

a. If the needed medical service is available from a PPO provider in the area where the service is to be performed and the covered person chooses not to use the preferred provider, or if a covered person receives an eligible prescription drug from a non-network in-state pharmacy, benefits will be paid at 50 percent (after deductibles) of negotiated fee.

b. If the needed medical service is not available from a PPO provider in the area where the service is to be performed, or if a covered person receives an eligible prescription drug from a non-network out-of-state pharmacy, benefits will be paid at 80 percent (after deductibles) of negotiated fee."

F. Amend item 4 in redesignated footnote "****" on page 5 to read as follows:

"**** ...4) expenses for prescription drugs (never eligible for 100 percent reimbursement)."

Amendment Number 2

Amend Article 1, Section I, Subsection P to read as follows:

"P. The term *PPO* as used herein shall mean a Preferred Provider Organization. A PPO is a medical provider such as a hospital, doctor or clinic who has entered into a contractual agreement with the Program to provide medical services to covered persons at a reduced or discounted price. In return, the Program has agreed to reimburse the PPO at an increased level of benefits.

With reference to outpatient prescription drug benefits only, the term *Network Pharmacy* as used herein shall mean a pharmacy which participates in a network established and maintained by a third-party prescription benefits management firm with which the Program has contracted to provide and adjudicate prescription drug benefits."

Amendment Number 3

Amend Article 3, Section I, Subsection C, Paragraphs 1, 2, and 4, and add a new Paragraph 5, to read as follows:

"C. Benefits for Eligible Medical Expenses

When disease, illness, accident or injury requires the covered person to incur any of the eligible expenses defined herein, ...

1. 50 percent of the first $5,000 of eligible expenses incurred with non-PPO providers in an area where PPO contracts are in force and can provide the needed medical service;

2. 80 percent of the first $5,000 of eligible expenses incurred in areas where no PPO contracts are in place or where PPO providers cannot provide the needed medical service;

3. ...

4. except for prescription drugs, 100 percent of eligible expenses in excess of $5,000 for the remainder of the calendar year subject to the maximum amount as specified in the Schedule of Benefits; and

5. the percentage payable for eligible outpatient prescription drug expenses shall be determined in accordance with the provisions of Article 3, Section XI."

Amendment Number 4

Amend Article 3, Section I, Subsection E, to read as follows:

"E. Restoration of Comprehensive Medical Benefits

For all Comprehensive Medical Benefits under Article 3, Section I, other than Outpatient Prescription Drug benefits on and after January 1, 1996, the automatic annual restoration amount as stated in the Schedule of Benefits shall be restored by the Plan on each January 1."

Amendment Number 5

Amend Article 3, Section I, Subsection F, Preamble and Paragraphs 8, 9, 10, and 11, and add a new Paragraphs 36 and 37, to read as follows:

"F. Eligible Expenses

The following shall be considered eligible expenses except when related to or in connection with non-covered procedures as listed in Section VIII of this Article. These eligible expenses shall be subject to applicable limitations of the Fee Schedule and the Schedule of Benefits, under Comprehensive Medical Benefits when prescribed by a physician and medically necessary for the treatment of a covered person:

* * *

8. Subject to the provisions of Article 3, Section XI, and the limitations and deductibles specified in the Schedule of Benefits, drugs and medicine approved by the Food and Drug Administration or its successor, requiring a prescription, dispensed by a licensed pharmacist or pharmaceutical company, but which are not administered to a covered person as an inpatient hospital patient or as an outpatient surgical patient, including insulin, Retin-A dispensed for covered persons under the age of 26, vitamin B12 injections, and prescription potassium chloride, but not including items listed in Article 3, Section VIII(W);

9. Over the counter diabetic supplies, subject to the provisions of Article 3, Section XI, and the limitations and deductibles for prescription drugs specified in the Schedule of Benefits;

10. Surgical supplies and medical supplies as listed below:

Catheters - External and Internal
Cervical Collar
IV Connectors
IV Tubing
Kidney Dialysis Supplies
Leg Bags for Urinal Drainage
Ostomy Supplies
Prosthetic Socks

Prosthetic Sheath
Sling (Arm or Wrist)
Suction Catheter for Oral Evacuation
Surgical Shoe (Following Foot Surgery Only);

11. Intravenous injections, solutions, and eligible related intravenous supplies, except in conjunction with home health care services;

* * *

36. Oxygen and equipment necessary for its administration; and

37. Services and supplies included in an approved treatment plan pursuant to the Case Management provisions in Section IV of this Article."

Amendment Number 6

Amend Article 3, Section VI, Subsection E, Paragraph 2, relative to outpatient benefits under the Catastrophic Illness Endorsement by deleting subparagraph c, relative to drugs and medicines, in its entirety and redesignating subparagraphs d and e as c and d, respectively.

Amendment Number 7

Amend Article 3, Section VIII, Subsections W and KK to read as follows:

"VIII. Exceptions and Exclusions for All Medical Benefits

No benefits are provided under this contract for:

* * *

W. Appetite suppressant drugs, dietary supplements, topical forms of Minoxidil, Retin-A dispensed for covered persons over age 26, nutritional or parenteral therapy, vitamins and minerals, and drugs available over the counter;

* * *

KK. Expenses for services rendered by a dentist or oral surgeon and any ancillary or related services, except for covered dental surgical procedures (Article 3, Section V), dental procedures which fall under the guidelines of Article 3, Section I(F)(15), procedures necessitated as a result of or secondary to cancer, or oral and maxillofacial surgeries which are shown to the satisfaction of the program to be medically necessary, non-dental, non-cosmetic procedures;"

* * *

Amendment Number 8

Amend Article 3, Section X, Subsection B, Paragraph 2 to read as follows:

2. If a non-PPO provider is used in an area where there are PPO providers of the same service, then the plan member is reimbursed 50 percent of the eligible expenses. If there is no PPO provider of the same service in the area where the service is provided, then the plan member is reimbursed 80 percent of eligible expenses. If services are received from a PPO, then services are reimbursed at 90 percent of the PPO rate with payments made to the PPO provider. These are all made subject to deductibles to the PPO provider. There is contractual assignment to every PPO provider."

Amendment Number 9

Amend Article 3, by adding a new Section XI to read as follows:

"XI. Prescription Drug Benefits

Effective January 1, 1996, outpatient prescription drug benefits are adjudicated by a third-party prescription benefits management firm with whom the Program has contracted. In addition to all provisions, exclusions and limitations relative to prescription drugs set forth elsewhere in this Plan Document, the following shall apply to expenses incurred for outpatient prescription drugs:

A. Upon presentation of the Group Benefits Program identification card at a network pharmacy, the plan member shall be responsible for payment of 10 percent of eligible charges for the drug, with a minimum copayment of $3 per prescription, provided, however, that in no event will a combination of payments made by the prescription benefits management firm and the plan member exceed the actual charge by the pharmacy for the drug.

B. In the event the plan member does not present the Group Benefits Program identification card to the network pharmacy at the time of purchase, the plan member shall be responsible for full payment for the drug and must then file a claim with the prescription benefits management firm for reimbursement, which shall be limited to the rates established for non-network pharmacies.

C. In the event the plan member obtains a prescription drug from an in-state non-network pharmacy, benefits shall be limited to 50 percent and benefits for prescription drugs obtained from an out-of-state non-network pharmacy shall be limited to 80 percent. In either event, a plan member must submit a claim to the prescription benefits management firm in order to receive benefits.

D. Regardless of where the prescription drug is obtained, eligible expenses for single-source brand name drugs shall be limited to the prescription benefits management firm's maximum allowable charge and eligible expenses for generic drugs and for brand name drugs for which a generic equivalent is manufactured shall be limited to the prescription benefits management firm's generic maximum allowable charge.

E. Prescription drug dispensing and refills shall be limited in accordance with protocols established

by the prescription benefits management firm, including the following limitations:

1. up to a 34-day supply of acute drugs may be dispensed at one time;
2. up to a 90-day supply of maintenance drugs may be dispensed at one time; and
3. refills will be available only after 75 percent of drugs previously dispensed should have been consumed.

F. The Board of Trustees reserves the authority to administratively adopt prior authorization and/or case management procedures governing the terms and conditions under which expenses for certain drugs are considered eligible."

Amendment Number 10

Amend Article 4, Section II to read as follows:

"II. Deadline for Filing Claims

A properly submitted claim for benefits as a result of any disease, illness, accident or injury must be received by the State Employees Group Benefits Program, or for outpatient prescription drug benefits, by the prescription benefits management firm, by 4:30 p.m., close of business, on June 30 next following the end of the calendar year in which the medical expenses were incurred. When June 30 is a non-work day, the deadline is automatically extended to 4:30 p.m. of the next regular workday. Each expense shall constitute a separate claim."

Amendment Number 11

Amend Article 4 by deleting Section IV, relative to filing claims for prescription drugs, in its entirety and redesignating Sections V through XVIII as IV through XVII, respectively.

Amendment Number 12

Amend Article 5, Section IV by adding a new subsection C to read as follows:

"IV. Request for Review

A plan member, affected by an initial determination, may appeal the determinations in the following manner:

* * *

C. The foregoing notwithstanding, an appeal from the disallowance of a claim relating to outpatient prescription drug benefits may not be filed until all review and appeal procedures available through the prescription benefits management firm have been exhausted. The appeal must be filed within 90 days of the prescription benefits management firm's final determination, a copy of which must be included with the request for appeal."

Interested persons may present their views, in writing, to James R. Plaisance, Executive Director, State Employees Group Benefits, Box 44036, Baton Rouge, LA 70804, until 4:30 p.m. on Friday, February 23, 1996.

James R. Plaisance
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Managed Prescription Drug Benefits

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Implementation costs of this rule change will directly affect the State Employees Group Benefits Program. According to the program's consulting actuary, The Segal Company it is anticipated that the first year savings associated with this rule change will be between $2,316,938 to $2,074,448.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Revenue collections of state and local governmental units will not be affected by this rule change.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The directly affected persons will be the plan members of the State Employees Group Benefits Program. Effective January 1, 1996 all prescription drug claims will be managed by a prescription benefits manager and all claims will be adjudicated on-line at the point of sale. In addition, an additional $250,000 lifetime maximum benefit has been established for prescription drugs effective January 1, 1996. The medical benefits lifetime maximum will now be subject to an automatic restoration in the full amount of $4,000.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Competition and employment will not be affected.

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